Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR UNIVERSITY MEDICAL CENTER
P O BOX 842022
DALLAS TX 75284-2022

Carrier's Austin Representative Box
#47

MFDR Date Received
MARCH 11, 2011

Respondent Name
AMERISURE MUTUAL INSURANCE CO

MFDR Tracking Number
M4-11-2324-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "denied for no authorization. This is ER visit no way to get pre auth"

Amount in Dispute: $103.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carriers position that the correct decision was made when the requestor's bills were denied on extent of injury, peer review, RME, treatment outside the ODG, and no pre-authorization. The Carrier acknowledges that compensable injury extends to include a cervical and lumbar strain and psychological disorders which was determined by a District Court Ruling, Cause No. 05-06158. Based upon this final judgment the compensable injury has been determined to ICD-9 codes included: 1. 295.03 – Paranoid Schizophrenia; 2. 847.0 – Cervical strain; 3. 847.2 – Lumbar strain…It is the Carrier's position that the correct decision was made when the requestor's bills for date of services 3/9/10, denied on extent of injury, per Peer and RME, and outside the ODG. The following ICD 9 codes are not compensable: 1. 698.9 – Unspecified pruritic disorder; 2. 338.29 – chronic pain; 3. 723.1 0 cervicalagia; 4. 724.2 – Lumbago; 5. 729.5 – Pain in limb; 6. 401.9 Essential hypertension, unspecified benign or malignant; 7. V58.69 – long term use of medications…"

Response Submitted by: Amerisure Insurance, 5221 North O'Connor Blvd., Suite 400, Irving, TX 75039-3711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 9, 2010	99281	$103.39	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 8, 2010
- 216 – BASED ON THE FINDINGS OF A REVIEW ORGANIZATION.
- PROCEDURE IS OUTSIDE ODG GUIDELINES/PREAUTH REQUIRED
- DENIAL PER PEER REVIEW/PEER REVIEW ATTACHED
- DENIAL PER RME/RME ATTACHED

Explanation of benefits dated February 14, 2011
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
- PROCEDURE IS OUTSIDE ODG GUIDELINES/PREAUTH REQUIRED
- DENIAL PER PEER REVIEW/PEER REVIEW ATTACHED
- DENIAL PER RME/RME ATTACHED

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the service in dispute listed on the requestors *Table of Disputed Services* shows March 9, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on March 11, 2011. This date is later than one year after the date(s) of service in dispute. The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 28, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.